

Screening Tools for Behavioral Health in Primary Care

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Screening Tools in Primary Care

Why?

Who?

When?

Where?

What?



Screening Tools in Primary Care- Why?

- 16.5 minutes of face-to-face time not working in the EHR
- For a mostly middle-aged, insured population, family physicians address 2.5 to 3.1 issues in the average clinic visit.
- The average number of issues per visit grows to 3.9 to 6 for elderly patients and 4.6 for patients with diabetes.
- Screening for early detection and treatment of mental and substance use disorders in primary care settings can improve quality of life, help contain health care costs, and reduce complications from co-occurring behavioral health and medical comorbidities



Screening Tools in Primary Care- Who?

Office Staff

Scripts and Letters

- “Here are a few questionnaires that Dr Coopey would like you to complete. These will only be reviewed by the medical staff and help Dr Coopey give you the best care possible. If you have any questions, please ask me, your medical assistant or Dr Coopey. You are welcome to sit in our confidential area while you complete these and place them in the envelope. Your health and privacy are important to us.”

Scheduling

- Increased visit time for Behavioral Health Screening
- Create follow up guidelines

Patient Portal

- Contacting patients before to complete screening via patient portal

Reimbursement

- Supporting you in documentation and billing for screening
- Helping you use technology



Screening Tools in Primary Care- Who?

Medical
Assistants and
RNs



Score Screens for your visit



Record the Screens in EMR

Unless done via patient
portal or IT device



Anticipate additional Screens



Checking Controlled
Substance Reporting Systems

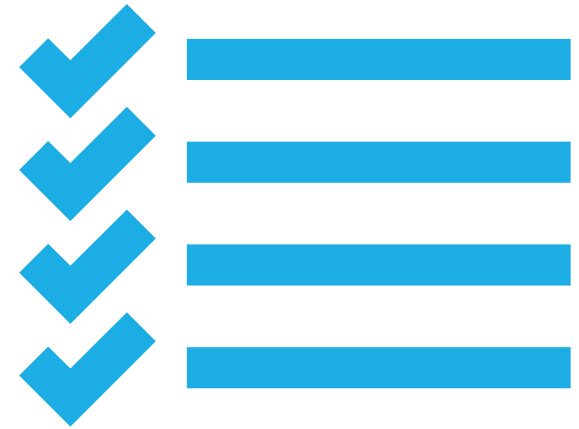
Reviewing prior to start of
day



Patient Education

Screening Tools in Primary Care- Where?

- Home
- Lobby
- Private area in the Lobby
- Exam Room
- With or without parents
- On Paper or Application



Screening Tools in Primary Care- When?



Before Visit

Planned Behavioral Health Visit
(ADHD evaluation)

Mailed paper has poor return

Opportunity for use of Technology



During

New concern voiced

Need schedule flexibility



After

Treatment Monitoring

Teamwork

Start Day Huddle

- Review patients for Day (AM/PM)
- Scales Prepared – new and f/u
- Controlled Substance Reporting System

Mid-day Huddle

- Repeat

End of Day Huddle

- Ask “How did it go?”

Screening Tools in Primary Care- What?

Ultra-short screeners with strong specificity tend to function best in ruling out disorders;

PCPs can be confident that patients who score negative on these screeners are true negatives and do not need follow-up. However, screeners with low sensitivity will yield a higher number of false positives, or may not provide enough information about specific disorders.

High Specificity = negative score are true negatives (No follow up needed)

Low Sensitivity = high number of false positives or not enough information

High sensitivity = people with the disorder being correctly identified (true positives).



Screening Tools in Primary Care- What?

Screen	Free	Self Report	Parent Report	Age Range	Sensitivity/Specificity in Primary
PHQ-2/9	✓	✓		13+	83/92, 88/88
PHQ-A	✓	✓		11-17	73/95
SCARED	✓	✓	✓	8-18	81.8/52
GAD-7	✓	✓		18+	88/89
Vanderbilt	✓	✓	✓	6-12	80/75
ASRS v1.1	✓	✓		18+	68.7/99.5
AUDIT-C/10	✓	✓		12+	86/78, 97/71
CRAFFT	✓	✓		14-18	80/86
MDQ	✓	✓			25/99

Depression Screening

Patient Health Questionnaire – PHQ

- PHQ-2
- PHQ-9
- PHQ-A

Screening for Anxiety Disorders

Generalized Anxiety Disorder Scale – GAD-7

Screen for Child Anxiety Disorders - SCARED

ADHD Screens

Vanderbilt Assessment Scales

- Parent Report
- Teacher Report

Adult ADHD Self Report Scale - ASRS v1.1

Highly Specific - good at ruling out the disorder

Poorly Sensitive – more false positives

Substance Use Disorder Screening

Alcohol Use Disorders Identification Test

AUDIT – 10

- 97/71

AUDIT- C

- 86/78

Screening for Bipolar Disorder

Mood Disorders Questionnaire - MDQ

- 25/99
- Poorly Sensitive – False Positives
- Highly Specific – True Negatives
- Good for specific inquiry

CIDI Bipolar Disorder Screening Scale

Composite International Diagnostic Interview WHO

3-min clinician-administered screen beginning with two stem questions.

Question 1. *“Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?”*

Question 2: *“Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people or hit people?”*

If the answers to the two stem questions are “no”, then the CIDI is considered negative. Patients who answer “yes” to either stem question require a full CIDI assessment.

The CIDI scale was concordant with the gold-standard SCID-IV (kappa 0.88 for bipolar I disorder and kappa 0.88 for bipolar II disorder or subthreshold bipolar disorder symptoms) in a national household survey, suggesting that the CIDI could be used as a case-finding measure for bipolar disorder

Combination Screens



Patient Stress Questionnaire is a tool used in primary care settings to screen for behavioral health symptoms. It was adapted from the **PHQ-9**, **GAD-7**, **PC-PTSD**, and **AUDIT**.



Three of these four tools (the PHQ-9, GAD-7, and AUDIT-10) have been adapted into ultra-short screening tools from the parent instruments—the PHQ-4 that includes two-item screeners for depression (PHQ-2) and anxiety (GAD-2), and the AUDIT-C, a three-item screener for alcohol problems. The PHQ-2, PHQ-4, and GAD-2 have sound psychometrics, but their sensitivity is lower than their specificity.



Ultra-short screeners with strong specificity tend to function best in ruling out disorders



National Comorbidity Studies

The National Comorbidity Survey – Replication (NCS-R) is a nationally representative face-to-face household survey conducted between February 2001 and April 2003 using the fully structured World Health Organization World Mental Health Survey version of the Composite International Diagnostic Interview.

The National Comorbidity Survey–Adolescent Supplement NCS-A is a nationally representative face-to-face survey of 10,123 adolescents aged 13 to 18 years in the continental United States. *DSM-IV* mental disorders were assessed using a modified version of the fully structured World Health Organization Composite International Diagnostic Interview.

National Comorbidity Study Replication

2001-2003

Table 3. Ages at Selected Percentiles on the Standardized Age-of-Onset Distributions of *DSM-IV*/WMH-CIDI Disorders, With Projected Lifetime Risk at Age 75 Years

	Projected Lifetime Risk at Age 75 y, % (SE)	Age at Selected Age-of-Onset Percentiles, y							
		5	10	25	50	75	90	95	99
Anxiety Disorders									
Panic disorder	6.0 (0.3)	6	10	16	24	40	51	56	63
Agoraphobia without panic	1.6 (0.2)	6	7	13	20	33	48	51	54
Specific phobia	13.2 (0.4)	4	5	5	7	12	23	41	64
Social phobia	12.6 (0.4)	5	6	8	13	15	23	34	52
Generalized anxiety disorder	8.3 (0.4)	8	13	20	31	47	58	66	75
Posttraumatic stress disorder*	8.7 (0.6)	6	9	15	23	39	53	61	71
Obsessive-compulsive disorder†	1.9 (0.3)	10	11	14	19	30	48	54	54
Separation anxiety disorder‡	5.2 (0.4)	5	5	6	7	10	13	14	17
Any anxiety disorder§	31.5 (1.1)	5	5	6	11	21	41	51	65
Mood Disorders									
Major depressive disorder	23.2 (0.6)	12	14	19	32	44	56	64	73
Dysthymia	3.4 (0.3)	7	11	17	31	43	51	57	73
Bipolar I-II disorders	5.1 (0.3)	11	13	17	25	42	50	57	65
Any mood disorder	28.0 (0.8)	11	13	18	30	43	54	63	73
Impulse-Control Disorders									
Oppositional-defiant disorder‡	8.5 (0.7)	5	6	8	13	14	16	17	18
Conduct disorder‡	9.5 (0.8)	6	7	10	13	15	17	17	18
Attention-deficit/hyperactivity disorder‡	8.1 (0.6)	5	6	7	7	8	11	11	16
Intermittent explosive disorder	5.4 (0.3)	6	8	11	15	20	26	37	46
Any impulse-control disorder‡	25.4 (1.1)	5	6	7	11	15	18	23	36
Substance Use Disorders									
Alcohol abuse*	15.1 (0.7)	15	16	18	21	29	39	44	54
Alcohol dependence*	6.5 (0.4)	16	17	19	23	31	41	50	56
Drug abuse*	8.5 (0.4)	15	16	17	19	23	29	36	46
Drug dependence*	3.4 (0.3)	15	16	18	21	28	36	41	49
Any substance use disorder§	16.3 (0.6)	15	16	18	20	27	37	41	54
Any Disorder									
Any disorder§	50.8 (1.2)	5	5	7	14	24	42	51	64

Abbreviation: WMH-CIDI, World Mental Health Survey version of the Composite International Diagnostic Interview.

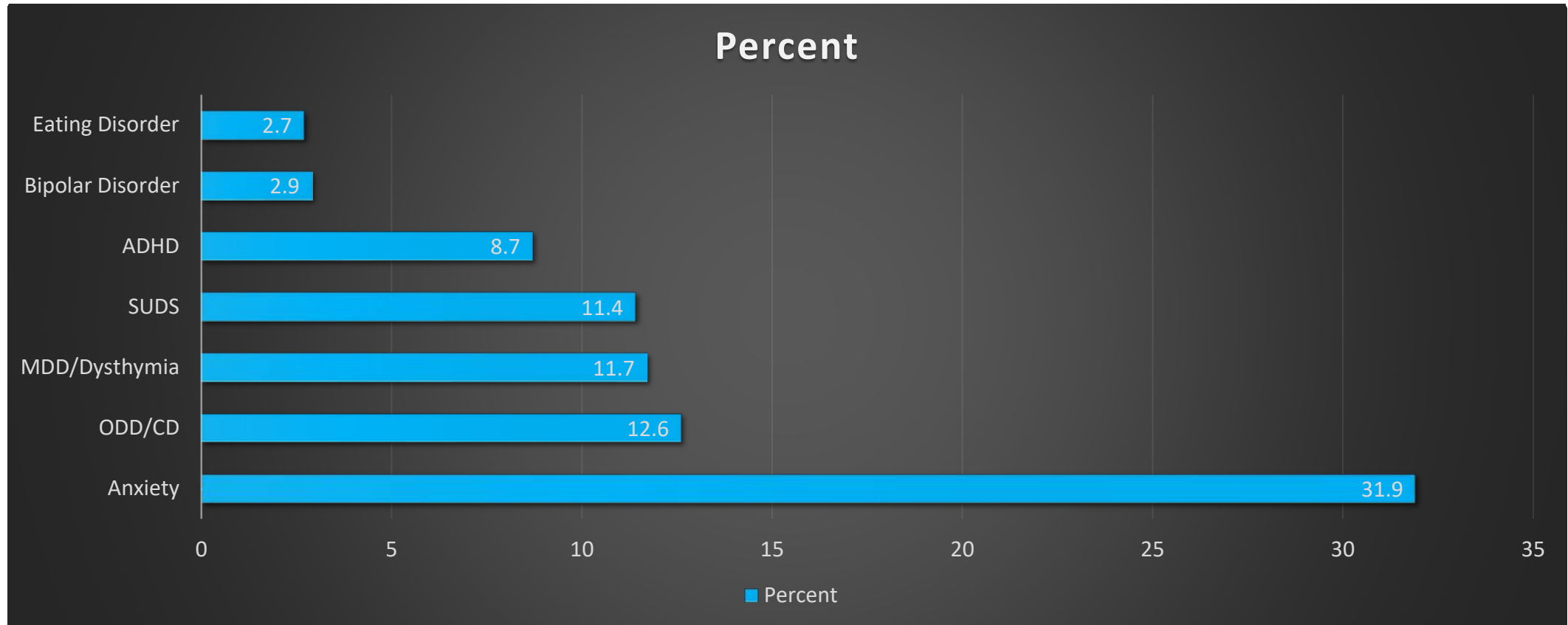
*Assessed only in the part II sample (n = 5692).

†Assessed only in a random third of the part II sample (n = 1808).

‡Assessed only among part II respondents aged 18 to 44 years (n = 3199).

§These summary measures were analyzed in the full part II sample (n = 5692). Obsessive-compulsive disorder, separation anxiety disorder, oppositional-defiant disorder, conduct disorder, and attention-deficit/hyperactivity disorder were coded as absent among respondents who were not assessed for these disorders.

NCS-Adolescent Lifetime Prevalence



National Comorbidity Studies

Anxiety disorders were the most common condition (31.9%), followed by behavior disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%)

Approximately 40% of participants with one class of disorder also meeting criteria for another class of lifetime disorder.

The overall prevalence of disorders with severe impairment and/or distress was 22.2% (11.2% with mood disorders, 8.3% with anxiety disorders, and 9.6% behavior disorders).

The median age of onset for disorder classes was earliest for anxiety (6 years), followed by 11 years for behavior, 13 years for mood, and 15 years for substance use disorders.

MC Comorbid Conditions with ADHD

#1 - Oppositional Defiant disorder, prevalence 41%

- Co-occurs in 50% of children with ADHD combined type
- Co-occurs in 25% of children with predominantly inattentive type

#2- Minor Depressive Disorder/Dysthymia, prevalence of 22%.

#3- Generalized Anxiety Disorder, prevalence 15%

- Occurs in minority of individuals with ADHD, but more often than general population.

Next Steps

- Systems in Place – in order to use tools consistently
 - Start with 1 tool and build QI project around it
 - Use your team
- Screening is an intervention
- Primary Care is a Treatment

Next Steps

- Brief Intervention Strategies

- Education
- Addressing Stressors
- Activation Social Supports
- Physical Activity
- Follow-up

Evidence Based Strategies

- Motivational Interviewing
- SBIRT – Screening Brief Intervention and Referral to Treatment

References

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